Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **04 - MAIN LIC** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 04/22/19 at Florida Mentor, Lic # 4023096, an Intermediate Care Facility for Individuals with Intellectual Disabilities in Lantana, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-26, and Florida Statutes (F.S.) 400 Part IL, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies, found at the time of the visit.	Y 000		
Y1006	NFPA 101 Considerations not Related to Fire The Code also addresses other considerations that, while important in fire conditions, provide an ongoing benefit in other conditions of use, including non-fire emergencies. NFPA 101 (2012) 1.1.5. This STANDARD is not met as evidenced by: Based on a review of the facility provided documentation and interview of staff, the facility failed to provide a security management plan. This deficient practice can affect all smoke compartments, staff, visitors and residents. The findings included: On 04/22/19 at 2:00 P.M. during a review of the	Y1006		

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Y1006	Continued From page 1 facility documentation, no security management plan was available for review. Concurrent at this time, the Maintenance Director said he was unaware of having a facility security management plan. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the time of document review, staff interview and at the exit conference on 04/22/19. per NFPA 99 (2015) Chapter 13	Y1006		

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	10G053	A. BUILDING **02 - BUILDING 2** B. WING _____	**04/22/2019**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on 4/22/19 at Florida Mentor, an Intermediate Care Facility for Individuals with Intellectual Disabilities in Lantana, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-26, and Florida Statutes (F.S.) 400 Part IL, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2012) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Facility as surveyed was built or licensed in 1982 and is consistent with Type II (000) construction (no approved building plans were available to verify this information). The facility consists of three buildings containing 8 resident beds in each for a total of 24 resident beds. Each building has a supervised fire alarm system and a complete automatic fire sprinkler system. All three buildings share 1 emergency generator. The buildings are identified as Building 1, 2 and 3. The facility is surveyed under the requirements of NFPA 101 (2012) Chapter 19 due to residents incapability of self preservation. Building # 2. The following is description of the deficiencies, found at the time of the visit.	K 000		
K 271	Discharge from Exits CFR(s): NFPA 101	K 271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **02 - BUILDING 2** B. WING _____	**04/22/2019**

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K 271	Continued From page 1 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep exits free from obstructions Exterior egress paths shall not be blocked or restricted which could impede the exiting of occupants in an emergency and result in harm to the occupants from the dangers of the emergency situation. The findings included: On 04/22/19 between 8:00 A.M. and 9:00 A.M. when touring the exterior of the three buildings, the exit egress paths between each building has trees and bushes which are overgrown and impeding clear egress of all buildings to a point of safety. Concurrent with the observations, the Maintenance Director was aware of the landscape overgrowth and said they had people to cut the overgrowth.	K 271		
K 345	NFPA 101 (2012) Ch. 19, Ch. 7 Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 2 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on observation during document review, the facility failed to maintain the Fire Alarm System. Maintaining the Fire Alarm System ensures proper operation and lessens the chance of a delayed alarm activation under hazardous conditions. The findings included: During document review with the Maintenance Director on 04/22/19 at 1:15 P.M., the facility failed to provide evidence of the biennial sensitivity inspection. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. per NFPA 101(2012) 19.3.4.4, 9.6.1.5 per NFPA 72 (2010) 14.4.5.3	K 345		
K 917	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on facility tour and interview with the Maintenance Director, the facility failed to identify life safety and critical care outlets and switches. Failure to identify life safety and critical care outlets and switches could delay care to residents	K 917		

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K 917	Continued From page 3 in a public utility power failure. The findings included: During the facility tour with the Maintenance Director on 04/22/19 at 11:15 A.M., it was revealed that the facility failed to identify life safety and critical branch outlets and switch covers with distinctive color or markings. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. Building # 2. per NFPA 99 (2012) 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	K 917		

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Y 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 04/22/19 at Florida Mentor, Lic # 4023096, an Intermediate Care Facility for Individuals with Intellectual Disabilities in Lantana, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-26, and Florida Statutes (F.S.) 400 Part IL, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Facility as surveyed was built or licensed in 1982 and is consistent with Type II (000) construction (no approved building plans were available to verify this information). The facility consists of three buildings containing 8 resident beds in each for a total of 24 resident beds. Each building has a supervised fire alarm system and a complete automatic fire sprinkler system. All three buildings share 1 emergency generator. The buildings are identified as Building 1, 2 and 3. The facility is surveyed under the requirements of NFPA 101 (2015) Chapter 19 due to residents incapability of self preservation. Building # 2. The following is description of the deficiencies, found at the time of the visit.	Y 000		
Y1003	NFPA 101 Features Maintained Whenever or wherever any device, equipment,	Y1003		

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Y1003	Continued From page 1 system, condition, arrangement, level of protection, fire resistive construction, or any other feature is required for compliance with the provisions of the Life Safety Code, such device, equipment, system, condition, arrangement, level of protection, fire resistive construction, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 101 (2012) 4.6.12.1 This STANDARD is not met as evidenced by: Based on facility tour and interview with the Maintenance Director, the facility failed to identify life safety and critical care outlets and switches. Failure to identify life safety and critical care outlets and switches could delay care to residents in a public utility power failure. The findings included: During the facility tour with the Maintenance Director on 04/22/19 at 12:15 P.M., it was revealed that the facility failed to identify life safety and critical branch outlets and switch covers with distinctive color or markings. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. Building # 3. per NFPA 99 (2015) 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	Y1003		
YS211	NFPA 101 Means of Egress - General Means of Escape - General	YS211		

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YS211	Continued From page 2 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep exits free from obstructions. Exterior egress paths shall not be blocked or restricted which could impede the exiting of occupants in an emergency and result in harm to the occupants from the dangers of the emergency situation. The findings included: On 04/22/19 between 8:00 A.M. and 9:30 A.M. when touring the exterior of the three buildings, the exit egress paths between each building has trees and bushes which are overgrown and impeding clear egress of all buildings to a point of safety. Concurrent with the observations, the Maintenance Director was aware of the landscape overgrowth. NFPA 101 (2015) Ch. 19, Ch. 7	YS211		

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	10G053	A. BUILDING **03 - BUILDING 3** B. WING _____	**04/22/2019**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on 4/22/19 at Florida Mentor, an Intermediate Care Facility for Individuals with Intellectual Disabilities in Lantana, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-26, and Florida Statutes (F.S.) 400 Part IL, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2012) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Facility as surveyed was built or licensed in 1982 and is consistent with Type II (000) construction (no approved building plans were available to verify this information). The facility consists of three buildings containing 8 resident beds in each for a total of 24 resident beds. Each building has a supervised fire alarm system and a complete automatic fire sprinkler system. All three buildings share 1 emergency generator. The buildings are identified as Building 1, 2 and 3. The facility is surveyed under the requirements of NFPA 101 (2012) Chapter 19 due to residents incapability of self preservation. Building # 3. The following is description of the deficiencies, found at the time of the visit.	K 000		
K 271	Discharge from Exits CFR(s): NFPA 101	K 271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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K 271	Continued From page 1 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep exits free from obstructions. Exterior egress paths shall not be blocked or restricted which could impede the exiting of occupants in an emergency and result in harm to the occupants from the dangers of the emergency situation. The findings included: On 04/22/19 between 8:00 A.M. and 9:00 A.M. when touring the exterior of the three buildings, the exit egress paths between each building has trees and bushes which are overgrown and impeding clear egress of all buildings to a point of safety. Concurrent with the observations, the Maintenance Director was aware of the landscape overgrowth.	K 271		
K 345	NFPA 101 (2012) Ch. 19, Ch. 7 Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		

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K 345	Continued From page 2 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on observation during document review, the facility failed to maintain the Fire Alarm System. Maintaining the Fire Alarm System ensures proper operation and lessens the chance of a delayed alarm activation under hazardous conditions. The findings included: During document review with the Maintenance Director on 04/22/19 at 1:15 P.M., the facility failed to provide evidence of the biennial sensitivity inspection. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. per NFPA 101(2012) 19.3.4.4, 9.6.1.5 per NFPA 72 (2010) 14.4.5.3	K 345		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		

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K 353	Continued From page 3 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on document review, interview with the Maintenance Director, the facility failed to maintain required inspections of the automatic fire sprinkler system (AFSS). Failure to maintain or have inspected, the system could lead to an AFSS failure. During document review on 04/22/19 at 9:00 A.M., the facility failed to provide evidence of repairing the non-functional water gong that has been written in all the certifications since March of 2018 in buildings 1 and 3. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings.	K 353		
K 917	Per NFPA 101 (2012) 19.3.5, 9.7 Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on facility tour and interview with the Maintenance Director, the facility failed to identify life safety and critical care outlets and switches. Failure to identify life safety and critical care	K 917		

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K 917	Continued From page 4 outlets and switches could delay care to residents in a public utility power failure. The findings included: During the facility tour with the Maintenance Director on 04/22/19 at 12:15 P.M., it was revealed that the facility failed to identify life safety and critical branch outlets and switch covers with distinctive color or markings. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. Building # 3. per NFPA 99 (2012) 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	K 917		
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 5 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on facility tour and interview with the Maintenance Director, the facility failed to prevent the use of power strips, multi-outlet adapters, and extension cords in resident care areas. Electrical fires can start when circuits are overloaded in the walls or attic where it can go undetected, giving the hazard time to spread, placing the facility at risk. The findings included: During the facility tour with the Maintenance Director on 04/22/19 at 12:15 P.M., it was revealed the facility prevented use of multi-outlet adapters and extension cords in resident room 1 of building 3. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings.	K 920		
K 921	per NFPA 99 (2012) 10.2.3.6, 10.2.4 Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and	K 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 6 protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is not met as evidenced by: Based on observation and review of the equipment certification tag and interview with the Maintenance Director, the facility failed to conduct electrical testing of fixed and portable medical equipment. Failure to test medical equipment in patient care area could result in electrical shock or possible death to resident and or staff. This could affect residents and staff in the facility. The findings included: During tour with the Maintenance Director on 04/22/19 at 12:15 P.M., it was revealed that based on no certification sticker's or paperwork of the suction pump, humidifier, and nebulizer in	K 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 7 room 1 of building #3, the equipment had not been tested by a qualified person. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. Per NFPA 99 (2012) 10.3, 10.5.2.1	K 921		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 04/22/19 at Florida Mentor, Lic # 4023096, an Intermediate Care Facility for Individuals with Intellectual Disabilities in Lantana, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-26, and Florida Statutes (F.S.) 400 Part IL, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Facility as surveyed was built or licensed in 1982 and is consistent with Type II (000) construction (no approved building plans were available to verify this information). The facility consists of three buildings containing 8 resident beds in each for a total of 24 resident beds. Each building has a supervised fire alarm system and a complete automatic fire sprinkler system. All three buildings share 1 emergency generator. The buildings are identified as Building 1, 2 and 3. The facility is surveyed under the requirements of NFPA 101 (2015) Chapter 19 due to residents incapability of self preservation. Building # 3. The following is description of the deficiencies, found at the time of the visit.	Y 000		
Y1003	NFPA 101 Features Maintained Whenever or wherever any device, equipment,	Y1003		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y1003	Continued From page 1 system, condition, arrangement, level of protection, fire resistive construction, or any other feature is required for compliance with the provisions of the Life Safety Code, such device, equipment, system, condition, arrangement, level of protection, fire resistive construction, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 101 (2012) 4.6.12.1 This STANDARD is not met as evidenced by: Based on facility tour and interview with the Maintenance Director, the facility failed to identify life safety and critical care outlets and switches. Failure to identify life safety and critical care outlets and switches could delay care to residents in a public utility power failure. The findings included: During the facility tour with the Maintenance Director on 04/22/19 at 12:15 P.M., it was revealed that the facility failed to identify life safety and critical branch outlets and switch covers with distinctive color or markings. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. Building # 3. per NFPA 99 (2015) 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	Y1003		
Y1005	NFPA 101 General Equipment Testing & Maintenance	Y1005		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y1005	Continued From page 2 Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. NFPA 101 (2012) 4.6.12.4 This STANDARD is not met as evidenced by: Based on observation and review of the equipment certification tag and interview with the Maintenance Director, the facility failed to conduct electrical testing of fixed and portable medical equipment. Failure to test medical equipment in patient care area could result in electrical shock or possible death to resident and or staff. This could affect residents and staff in the facility. The findings included: During tour with the Maintenance Director on 04/22/19 at 12:15 P.M., it was revealed that based on no certification sticker's or paperwork of the suction pump, humidifier, and nebulizer in room 1 of building #3, the equipment had not been tested by a qualified person. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. Per NFPA 99 (2015) 10.3, 10.5.2.1	Y1005		
YL353	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing	YL353		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
YL353	Continued From page 3 2012 EXISTING (Prompt and Slow) Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system was last checked _____ b) Who provided system test _____ c) Water system supply source_____ 33.3.3.5.1, 9.7.5, 9.7.7, 9.7.8, NFPA 25 This STANDARD is not met as evidenced by: Based on document review, and interview with the Maintenance Director, the facility failed to maintain required inspections of the automatic fire sprinkler system (AFSS). Failure to maintain or have inspected, the system could lead to an AFSS failure. The findings included: During document review on 04/22/19 at 9:00 A.M., the facility failed to provide evidence of the repairing of the non-functional water gong that has been written in all the certifications since March of 2018 in buildings 1 and 3. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings.	YL353		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **03 - BUILDING 3** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

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YL353	Continued From page 4 Per NFPA 101 (2015) 19.3.5, 9.7	YL353		
YS211	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep exits free from obstructions. Exterior egress paths shall not be blocked or restricted which could impede the exiting of occupants in an emergency and result in harm to the occupants from the dangers of the emergency situation. The findings included: On 04/22/19 between 8:00 A.M. and 9:30 A.M. when touring the exterior of the three buildings, the exit egress paths between each building has trees and bushes which are overgrown and impeding clear egress of all buildings to a point of safety. Concurrent with the observations, the Maintenance Director was aware of the landscape overgrowth. NFPA 101 (2015) Ch. 19, Ch. 7	YS211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **01 - BUILDING 1** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on 4/22/19 at Florida Mentor, an Intermediate Care Facility for Individuals with Intellectual Disabilities in Lantana, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2012) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-26, and Florida Statutes (F.S.) 400 Part IL, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2012) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Facility as surveyed was built or licensed in 1982 and is consistent with Type II (000) construction (no approved building plans were available to verify this information). The facility consists of three buildings containing 8 resident beds in each for a total of 24 resident beds. Each building has a supervised fire alarm system and a complete automatic fire sprinkler system. All three buildings share 1 emergency generator. The buildings are identified as Building 1, 2 and 3. The facility is surveyed under the requirements of NFPA 101 (2012) Chapter 19 due to residents incapability of self preservation. Building # 1, The following is description of the deficiencies, found at the time of the visit.	K 000		
K 271	Discharge from Exits CFR(s): NFPA 101	K 271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **01 - BUILDING 1** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

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K 271	Continued From page 1 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep exits free from obstructions. Exterior egress paths shall not be blocked or restricted which could impede the exiting of occupants in an emergency and result in harm to the occupants from the dangers of the emergency situation. The findings included: On 04/22/19 between 8:00 A.M. and 9:00 A.M. when touring the exterior of the three buildings, it was noted that the exit egress paths between each building has trees and bushes which are overgrown and impeding clear egress of all buildings to a point of safety. Concurrent with the observations, the Maintenance Director was aware of the landscape overgrowth.	K 271		
K 345	NFPA 101 (2012) Ch. 19, Ch. 7 Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **01 - BUILDING 1** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

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K 345	Continued From page 2 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on observation during document review, the facility failed to maintain the Fire Alarm System. Maintaining the Fire Alarm System ensures proper operation and lessens the chance of a delayed alarm activation under hazardous conditions. The findings included: During document review with Maintenance Director on 04/22/19 at 1:15 P.M., the facility failed to provide evidence of the biennial sensitivity inspection. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. per NFPA 101(2012) 19.3.4.4, 9.6.1.5 per NFPA 72 (2010) 14.4.5.3	K 345		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **01 - BUILDING 1** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

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K 353	Continued From page 3 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on document review, interview with the Maintenance Director, the facility failed to maintain required inspections of the automatic fire sprinkler system (AFSS). Failure to maintain or have inspected, the system could lead to an AFSS failure. The findings included: During document review on 04/22/19 at 9:00 A.M., the facility failed to provide evidence of repairing the non-functional water gong that has been written in all the certifications since March of 2018 in buildings 1 and 3. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings.	K 353		
K 917	Per NFPA 101 (2012) 19.3.5, 9.7 Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on facility tour and interview with the Maintenance Director, the facility failed to identify	K 917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10G053	A. BUILDING **01 - BUILDING 1** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 917	Continued From page 4 life safety and critical care outlets and switches. Failure to identify life safety and critical care outlets and switches could delay care to residents in a public utility power failure. The findings included: During the facility tour with the Maintenance Director on 04/22/19 at 10:15 A.M., it was revealed that the facility failed to identify life safety and critical branch outlets and switch covers with distinctive color or marking. An interview was conducted with the Maintenance Director concurrent with the observations, and confirmed the findings. Building # 1. per NFPA 99 (2012) 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	K 917		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **01 - BUILDING 1** B. WING _____	**04/22/2019**

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FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

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Y 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 04/22/19 at Florida Mentor, Lic # 4023096, an Intermediate Care Facility for Individuals with Intellectual Disabilities in Lantana, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2015) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69 A-3, F.A.C. 69 A-53, F.A.C. 59 A-26, and Florida Statutes (F.S.) 400 Part IL, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2015) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. Facility as surveyed was built or licensed in 1982 and is consistent with Type II (000) construction (no approved building plans were available to verify this information). The facility consists of three buildings containing 8 resident beds in each for a total of 24 resident beds. Each building has a supervised fire alarm system and a complete automatic fire sprinkler system. All three buildings share 1 emergency generator. The buildings are identified as Building 1, 2 and 3. The facility is surveyed under the requirements of NFPA 101 (2015) Chapter 19 due to residents incapability of self preservation. Building # 1. The following is description of the deficiencies, found at the time of the visit.	Y 000		
Y1003	NFPA 101 Features Maintained Whenever or wherever any device, equipment,	Y1003		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IC25910014	A. BUILDING: **01 - BUILDING 1** B. WING _____	**04/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA MENTOR	**1285 FLAMINGO DRIVE** **LANTANA, FL 33462**

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Y1003	Continued From page 1 system, condition, arrangement, level of protection, fire resistive construction, or any other feature is required for compliance with the provisions of the Life Safety Code, such device, equipment, system, condition, arrangement, level of protection, fire resistive construction, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 101 (2012) 4.6.12.1 This STANDARD is not met as evidenced by: Based on facility tour and interview with the Maintenance Director, the facility failed to identify life safety and critical care outlets and switches. Failure to identify life safety and critical care outlets and switches could delay care to residents in a public utility power failure. The findings included: During the facility tour with the Maintenance Director on 04/22/19 at 12:15 P.M., it was revealed that the facility failed to identify life safety and critical branch outlets and switch covers with distinctive color or markings. An interview was conducted with the Maintenance Director concurrent with the observations and confirmed the findings. Building # 1. per NFPA 99 (2015) 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2	Y1003		
YL353	NFPA 101 Sprinkler System - Maintenance and Testing	YL353		

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YL353	Continued From page 2 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt and Slow) Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system was last checked _____ b) Who provided system test _____ c) Water system supply source_____ 33.3.3.5.1, 9.7.5, 9.7.7, 9.7.8, NFPA 25 This STANDARD is not met as evidenced by: Based on document review and interview with the Maintenance Director, the facility failed to maintain required inspections of the automatic fire sprinkler system (AFSS). Failure to maintain or have inspected, the system could lead to an AFSS failure. The findings included: During document review on 04/22/19 at 9:00 A.M., the facility failed to provide evidence of the repairing the non-functional water gong that has been written in all the certifications since March of 2018 in buildings 1 and 3. An interview was conducted with the Maintenance Director	YL353		

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YL353	Continued From page 3 concurrent with the observations and confirmed the findings. Per NFPA 101 (2015) 19.3.5, 9.7	YL353		
YS211	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep exits free from obstructions. Exterior egress paths shall not be blocked or restricted which could impede the exiting of occupants in an emergency and result in harm to the occupants from the dangers of the emergency situation. The findings included: On 04/22/19 between 8:00 A.M. and 9:30 A.M. when touring the exterior of the three buildings, the exit egress paths between each building has trees and bushes which are overgrown and impeding clear egress of all buildings to a point of safety. Concurrent with the observations, the Maintenance Director was aware of the landscape overgrowth. NFPA 101 (2015) Ch. 19, Ch. 7	YS211		

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E 000	Initial Comments During the unannounced Life Safety recertification survey conducted on 04/22/19 at Florida Mentor-Lantana, Florida, an Intermediate Care Facility for the Developmentally Disabled, Emergency Preparedness was requested for review. Florida Mentor-Lantana, is not in compliance with Emergency Preparedness per Intermediate Care Facilities for the Developmentally Disabled: code of Federal Regulations (CFR), 42 Part 483.475, Requirements for Intermediate Care Facility for the Developmentally Disabled Facilities. The following is description of the deficiencies, found at the time of the visit.	E 000		
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following	E 004		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide the annual review and update of their Emergency Preparedness Program (EP). Annual review and updating of the program is required to address the changing environments of the community, the facility and the facility population. The findings included: On 04/22/19 at 2:15 P.M. while reviewing the facility's EP with the Administrator, no evidence of annual updates and review by the facility administration was found. Concurrent with the review, the Administrator said that their plan had been implemented by the corporate office. The EP was required to be implemented by 11/16/16 in order to have annual updates and review completed by 11/16/17.	E 004		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]	E 006		

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E 006	Continued From page 2 (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to document and identify thru a risk assessment an all hazards approach in their Emergency Preparedness Program (EP). This in the event of a disaster or other emergency would leave the facility and its occupants vulnerable to the hazards of the event. The findings included: On 04/22/19 at 2:30 P.M. while reviewing the facility's EP, the hazards identified in the plan were not specific to the location in Lantana	E 006		

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E 006	Continued From page 3 Florida. Concurrent with the record review and during the exit conference, the Administrator said that their plan would need to be updated to meet the new Federal requirements including an all hazards approach and the addition of potential hazards to their program.	E 006		
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a succession plan in their Emergency Preparedness Program (EP) that would include the delegations of authority. This in the event of an emergency would leave the facility unable to provide leadership and other roles needed to execute the EP. The findings included: (1) On 04/22/19 at 2:30 P.M. while reviewing the facility EP with the Administrator, an indistinct succession plan was included in the EP. There	E 007		

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E 007	Continued From page 4 was a basic organizational chart but it did not indicate the delegation of authority for all positions. Concurrent with the review, the Administrator said that they would have to update the chart and their EP to include delegations of authority and succession plans. (2) On 04/22/19 at 2:30 P.M. while reviewing the facility EP with the Administrator, no policy or procedure was produced for prescribed oxygen to residents. No written formula or average use of oxygen E cylinders was available to sustain the residents requiring oxygen per doctor's orders. Concurrent with the review, the Administrator said that they would have to update the chart and their EP to include oxygen supply plans.	E 007		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 013		

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E 013	Continued From page 5 this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide the annual review and update of their Emergency Preparedness Program (EP). Annual review and updating of the program is required to address the changing environments of the community, the facility and the facility population. The findings included: On 04/22/19 at 2:45 P.M. while reviewing the facility's EP, no evidence of annual updates and review of the risk assessment and communication plan policy and procedures was found. The Administrator stated that they needed	E 013		

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E 013	Continued From page 6 to complete a communications plan and they were working on their annual facility administrative review.	E 013		
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036		

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E 036	Continued From page 7 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide emergency preparedness training and testing for the reviewed year. This in the event of an emergency would leave staff unprepared putting the patients, staff and occupants of the facility at risk to the hazards of the emergency. The findings included: On 04/22/19 at 2:00 P.M. when reviewing three staff members training files, no documentation was provided to show records of training, testing, and annual review of the program were provided. Concurrent with the review, the Administrator said that the plan would be reviewed and updated annually and training provided to all staff.	E 036		